Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEDICAL IMAGING OF PLANO
2109 WEST PARK RD SUITE 720
PLANO TX 75023

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

SERVICE LLOYDS INSURANCE CO

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-05-5052-01

MFDR Date Received

MARCH 10, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is our position that the insurance carrier failed to reimburse properly for this treatment, further more lacked to give serious consideration for resolving this claim. It has been discovered that the carrier has made payment but to the wrong provider and is making an argument that it is our responsibility to recoup those monies from that provider. In a correspondence on 1/28/2005 a representative (Jean Barts) was noted saying the only way this bill would be paid that if they are only ordered to pay by TWCC. Based upon this information our position is dispute fee reimbursement."

Amount in Dispute: $2,075.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier, or its agent, submitted a response to the request for medical fee dispute resolution; however, no position summary was included in this response.

Response Submitted by: Harris & Harris, PO Box 162443, Austin, TX 78716

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 29, 2004	CPT Codes 99499, 72132-WP-22, 72295-WP, 62290-51 (2x) HCPCS Codes A4646, A4550, A4215	$2,075.75	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.202 sets out the guidelines for reimbursement.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   The insurance carrier, or their audit company, did not submit EOBs to this health care provider. EOBs submitted by the requestor were EOBs received by Dr. Scott Lin, MD; showing payment was made to the physician performing the two level lumbar discogram.

Issues

1. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
2. Was the requestor reimbursement in accordance with 28 Texas Administrative Code §134.202?
3. Is the requestor entitled to reimbursement?

Findings

1. This request for medical fee dispute resolution was received by the Division on March 10, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on March 18, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule. The requestor has met the requirements of the rule and services will be review in accordance with the Texas Labor Code and Division rules.
2. Per Texas Administrative Code §134.202(b) for coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section; and (c)(1)To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%; (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (B)if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS.
   - CPT Code 72132-WP-22 is defined as computed tomography, lumbar spine; with contrast material; WP - whole person and Modifier 22 - identifies a service that required significantly greater effort than typically required; . Medicare prices this code at $309.18 x 125% (DWC conversion factor) = $386.48. According to the EOB, audit date of February 21, 2005, this amount was paid to Dr. Scott F. Lin, MD, 2109 W. Park Rd., Plano, TX 75023. Therefore the amount ordered is $0.00.
   - CPT Code 72295-WP is defined as discography, lumbar, radiological supervision and interpretation. Medicare prices this code at $316.27 x 125% (DWC conversion factor) - $395.46. According to the EOB, audit date of February 21, 2005, this amount was paid to Dr. Scott F. Lin, MD, 2109 W. Park Rd., Plano, TX 75023. Therefore the amount ordered is $0.00.
   - CPT Code 62290-51 is defined as an injection procedure for discography, each level; lumbar and was billed for two levels. Medicare prices this code at $345.15; the Multiple Procedure Reduction Guidelines apply. Therefore, the first level is reimbursed at $431.44 ($345.15 x 125% = $431.44; the second level, paid at 50%, reimbursement is $215.72. According to the EOB, audit date of February 21, 2005, this amount was paid to Dr. Scott F. Lin, MD, 2109 W. Park Rd., Plano, TX 75023. Therefore the amount ordered is $0.00.
   - HCPCS Code A4215 is defined as needle, sterile, any size, each. The requestor billed four (4) units of this code. Medicare DMEPOS does not price this code. The Texas Medicaid Fee Schedule prices this code at .16¢ each. .16¢ x 125% (DWC conversion factor) = .20¢ x 4 units = .80¢. According to the EOB, audit date of February 21, 2005, this amount was paid to Dr. Scott F. Lin, MD, 2109 W. Park Rd., Plano, TX 75023. Therefore the amount ordered is $0.00.
3. This remaining codes relate to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission." Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee

charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

- CPT Code 99499 is documented on the bill as 30 minute recovery.
- HCPCS Code A4646 is defined as supply of low osmolar contrast material (300-399 mgs of iodine).
- HPPCS Code A4550 is defined as surgical trays.

28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated. Therefore, reimbursement for the fair and reasonable codes is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		February 21, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.